STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155697	A. BUILDING 00 B. WING	11/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK REHABILITATION AND SKILLED NURSING CENTER	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for Investigation of Complaint IN00118464. Complaint IN00118464 - Substantiated. Federal/state deficiencies related to the allegations are cited at F309 and F314. Unrelated deficiency cited. Survey dates: November 13 and 14, 2012 Facility number: 000059 Provider number: 155697 AIM number: 100266560 Survey team: Jennie Bartelt, RN Census bed type: SNF: 6 SNF/NF: 63 Total: 69 Census payor type: Medicare: 12 Medicaid: 53 Other: 4 Total: 69 Sample: 3 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155697	A. BUILDING 00 B. WING	11/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK REHABILITATION AND SKILLED NURSING CENTER	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Quality review completed on November 16, 2012 by Bev Faulkner, RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155697	A. BUILDING 00 B. WING	11/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK REHABILITATION AND SKILLED NURSING CENTER	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to ensure the resident with complaints of nausea, vomiting, and diarrhea was assessed consistently for planning and implementing care as needed for 1 of 1 resident reviewed related to complaints of nausea, vomiting, and diarrhea in a sample of 3. (Resident C) Findings include: The clinical record for Resident C was reviewed on 11/13/12 at 12:00 p.m. The record indicated the resident was admitted to the facility on 9/16/12 following total knee replacement. The Progress Notes and Vitals Results from 9/16/12 until 9/28/12 did not indicate the resident had nausea, vomiting, or diarrhea. Progress Notes, dated 9/28/12 at 3:36 a.m., indicated, "Rests quietly abed. No drainage noted from incision site. Staples	F0309	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?Resident C was discharged to home How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?All residents have the potential to be affected by the alleged deficient practice.Review completed of residents and 1 resident did complain of loose stools and was added to hot charting for abdominal evaluation, description of stool, severity, fluid volume depletion and if any change of mental status. Licensed nurses will be in-serviced by SDC/designee 11/27/2012 on assessing residents with diarrhea to include vital signs, abdominal evaluation, description of bowel movement , severity, signs of possible fluid volume depletion and any change in mental status.** Any	11/28/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155697	A. BUILDING 00 B. WING	11/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK REHABILITATION AND SKILLED NURSING CENTER	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	intact. Continues ABT [antibiotic] r/t [related to] knee infection per MD order. No ADR [adverse drug reaction] noted. C/O [complains of] n/v/d [nausea, vomiting, diarrhea. PRN [as needed] Phenergan [anti-emetic] suppository given per MD order. Effective. Will call MD for order r/t diarrhea. Call light within reach." Documentation in Progress Notes and in Vitals Results failed to indicate an assessment of the resident including vital signs, description of the emesis and diarrhea including number of episodes and character of the emesis and diarrhea, observation of the abdomen, auscultation for bowel sounds, palpation of the abdomen, and indication of pain. Vitals Results on 9/28/12 at 7:07 a.m., indicated 99.0 degrees Fahrenheit. No other vital signs were indicated. A Nursing Progress Note on 9/28/12 at 7:22 a.m., indicated, "N.O. [new order] 4 mg Immodium [anti-diarrheal] P.O. [by mouth] now. 650 mg acetaminophen [pain/temperature medication] suppository q [every] 4 hours prn [as needed]. Stool sample for C-diff [Clostridium difficile - bacteria causing diarrhea] stat [immediately] CBC [complete blood count] and BMP [basic metabolic profile]."		resident identified during the clinical meeting with loose stools will be added to daily charting by the DNS/designee to assess every shift including vital signs, abdominal evaluation, description, fluid volume depletion and mental status changes. Plan of care will also be updated by the DNS/designee, with MD/family notification.Non-compliance with these practices will result in further education including disciplinary action.DNS/designee is responsible to ensure compliance.**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Review completed of residents and 1 resident did complain of loose stools and was added to hot charting for abdominal evaluation, description of stool, severity, fluid volume depletion and if any change of mental status. Licensed nurses will be in-serviced on assessing residents with diarrhea to include vital signs, abdominal evaluation, description of bowel movement , severity, signs of possible fluid volume depletion and any change in mental status.** Any resident identified during the clinical meeting with loose stools will be added to daily charting to assess every shift including vital	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155697	A. BUILDING _____ B. WING 00	11/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK REHABILITATION AND SKILLED NURSING CENTER	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A Physician Telephone Order, dated 9/28/12 at 7:20 a.m., indicated, "4 mg Immodium p.o. now, 650 mg acetaminophen suppository q 4 [symbol for hours] PRN, C-dif [sic] (before suppository), Stat CBC & BMP...." The Care Plan Update section of the Physician's Telephone Order indicated, "Problem: N/V/D T [temperature] - 99 [degrees]; Goal: Stop N/V/D and to bring temperature WNL [within normal limits]. The interventions were the same as the physician's orders. The Medication Administration Record for September 2012 indicated no acetaminophen suppository was administered. The next recorded Vital Signs were on 9/28/12 at 6:06 p.m., and the next Nursing Progress Note was 9/28/12 at 6:07 p.m. The Nursing Progress Note indicated, "Resident had two episodes of loose stools and no c/o nausea or vomiting. Lab results received indicating elevated WBC [white blood count]. New orders received to administer Rocephin [antibiotic] IM [intramuscular injection] now, to obtain stool sample for C-diff culture [second order received for this test], to obtain U/A [urinalysis] with C&S [culture and sensitivity], to obtain chest x-ray to r/o		signs, abdominal evaluation, description, fluid volume depletion and mental status changes. Plan of care will also be updated, with MD/family notification.Non-compliance with these practices will result in further education including disciplinary action.DNS/designee is responsible to ensure compliance. **How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?The CQI audit for change of condition will be utilized weekly x4, monthly x 6 and quarterly thereafter**Findings from the CQI process will be reviewed monthly a nd an action plan will be implemented as needed for any deficient practices below 95% threshold.The DNS/designee is responsible to ensure compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155697	A. BUILDING 00 B. WING	11/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK REHABILITATION AND SKILLED NURSING CENTER	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	[rule out] pneumonia, to begin Flagyl [antibiotic used in treatment of C. difficile diarrhea] 500mg po q 8 hr [every eight hours] X 10 days, and to begin contact precautions until results of stool culture received. Stool, and urine samples collected with lab notified of pick-up, chest x-ray ordered with tech [technician] to be in facility within four hours, Rocephin 1 gram in 2.1 ml of lidocaine solution administered to left ventro-gluteal site. Resident tolerated well and denies pain or soreness to injection area." Documentation failed to indicate an assessment of diarrhea including number of episodes and character of the diarrhea, observation of the abdomen, auscultation for bowel sounds, palpation of the abdomen, and indication of pain. The next Nursing Progress Note was 9/28/12 at 11:33 p.m., and indicated, "...Afebrile [no temperature indicated]....Started Flagyl tonight....Began contact precautions awaiting C-diff test results." Documentation failed to indicate an abdominal/bowel assessment or assessment of any on-going diarrhea. The next Nursing Progress Note was 9/29/12 at 1:39 a.m., and indicated, "Resident abed resting quietly no c/o			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155697	A. BUILDING 00 B. WING	11/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK REHABILITATION AND SKILLED NURSING CENTER	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	pain...diarrhea or distress alert and oriented X 3 [person, place, time] makes all needs known...bowel sounds are active X 4 quads [abdominal quadrants] abdomen is soft and nontender assisted with adls [activities of daily living] X 1 staff member when needed call light within reach." Vital Signs were documented on 9/29/12 at 1:46 a.m. The next Nursing Progress Note was on 9/29/12 at 1:34 p.m., and indicated, "...Remains on Flagyl r/t diarrhea and in contact isolation r/t poss [possible] c-diff. C/O loose stools. Will monitor." Documentation failed to indicate monitoring of vital signs or other assessments related to the diarrhea. No further Nursing Progress Notes were in the record until the resident was readmitted from the hospital on 10/4/12. The Discharge/Appointment/Transfer - Clark Rehab & Skilled Nursing Center Emergency Resident Transfer Form, dated 9/29/12 at 8:28 p.m., indicated, "Res has diarrhea since 9/28/12. C/O dizziness and weakness. Family requests transfer to [name of local hospital]....VS [vital signs] WNL [within normal limits]."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155697	A. BUILDING 00 B. WING	11/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK REHABILITATION AND SKILLED NURSING CENTER	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The hospital History and Physical, dated 9/30/12, indicated, "Chief Complaint: I had nausea and vomiting and diarrhea with severe abdominal cramping" and "History of Present Illness: (Name) ...who normally resides I believe at the Clark Rehab Center for a rehabilitation process involving her right total knee, which is actually excellent....She developed some issues of chills and fever with nausea, vomiting, cramping, diarrhea, abdominal distention, and came into the emergency room who [sic] was diagnosed with colitis, C. difficile specifically and diverticulitis...." During interview on 11/14/12 at 12:40 p.m., the Assistant Director of Nurses (ADON) indicated there were no other assessments of the resident related to the diarrhea. The ADON indicated the resident had had no problem with diarrhea previously since admission to the facility, but the resident had a history of diverticulitis. Review of the diagnoses lists on the resident's Physician Orders for September 2012 (prior to hospitalization on 9/29/12) and for October 2012 (after readmission on 10/4/12) indicated the diagnosis of acute and chronic diverticulitis was not indicated until after the hospitalization.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155697	A. BUILDING 00 B. WING	11/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK REHABILITATION AND SKILLED NURSING CENTER	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During interview on 11/14/12 at 4:05 p.m., the facility's Nurse Consultant and the ADON indicated the facility had no policy related to resident assessment for diarrhea. Review of the "American Medical Director Association's Know-it-all Before You Call Data Collection System" guides indicated related to Physical Data for assessment of diarrhea: "Vital signs, especially lying, sitting, and standing blood pressure (if obtainable) and pulse; Abdominal evaluation, including presence of abdominal pain, tenderness, distension, guarding; Detailed description of bowel movements, including quantity, frequency, consistency (loose, soft, water, etc.), severity, contents (blood, pus, mucus), etc.; If there has been continuous oozing of liquid stool (paradoxical diarrhea) perform a digital rectal evaluation to check for pain, tenderness, mass, or presence of hard, dry stool in the rectum; Any change in mental status, function, mood, behavior, or level of consciousness; Signs of possible fluid volume depletion or dehydration (postural pulse difference...tachycardia, rapid weight loss, cracked lips, thirst, new onset or increased confusion, fever)." This federal tag is related to Complaint IN00118464.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155697	A. BUILDING 00 B. WING	11/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK REHABILITATION AND SKILLED NURSING CENTER	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-37(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155697	A. BUILDING 00 B. WING	11/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK REHABILITATION AND SKILLED NURSING CENTER	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on record review and interview, the facility failed to prevent development of a pressure ulcer for a resident who entered the facility without a pressure ulcer. When the resident developed a pressure ulcer, the facility failed to monitor the resident's nutritional intake and check for fever, in accordance with the care plans. The deficient practice affected 1 of 1 resident reviewed with pressure ulcers in a sample of 3. (Resident A) Findings include: The clinical record for Resident A was reviewed on 11/13/12 at 3:20 p.m. The record indicated the resident was admitted from the hospital on 10/14/12 and discharged to the hospital on 11/7/12. The resident's care plan, dated 10/23/12, indicated the resident was at risk for skin breakdown related to decreased mobility,	F0314	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident A no longer resides in the facility **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?All residents have the potential to be affected by the alleged deficient practice. All residents currently with alterations with skin integrity were reviewed to ensure nutritional intake is monitored. Licensed nurses were inserviced on assessing residents skin upon admission and weekly, nutritional intakes and fevers by the wound nurse/designee on 11/27/2012 post test included on or before C.n.a's were re-educated on checking and changeing residents, and**	11/28/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155697	A. BUILDING 00 B. WING	11/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK REHABILITATION AND SKILLED NURSING CENTER	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	incontinence, a diagnosis of diabetes mellitus, and anemia. Progress Notes, dated 10/30/12 at 3:59 a.m., indicated, "This nurse is called into resident's room by cna [sic] to look at his coccyx area. Upon observation this nurse observes that the whole coccyx area is very red in color and on the right coccyx a stage 2 open area was measured 2 cm X 2 cm X 0.2 cm with no drainage observed. The left coccyx has a stage 1 area of dark purple under the skin measuring 4 cm X 5 cm with skin intact. [The American Medical Directors Association Pressure Ulcers in the Long Term Care Setting Clinical Practice Guidelines indicates, "Suspected deep tissue injury: Purple or maroon localized area of discolored intact skin...due to damage of underlying soft tissue from pressure and/or shear...."] Area is cleaned and an allevyn dressing is applied to the right stage 2 and magic butt cream is applied to the left buttock as ordered. will report to adon [Assistant Director of Nursing] [name] for appropriate treatment orders." A Physician Orders/Nursing Orders, dated 10/30/12 at 7:00 a.m., indicated, "Cleanse area to R [right] coccyx [with] normal saline. Pat dry apply Santyl cream to escar [sic] area and cover [with] alleven [sic] every day." The Care Plan Update		**turning/repositioning residents every 2 hours by the wound nurse/designee on or before 11/27/2012-post test included.Any wounds identified on admission or weekly skin assessment will be measured, MD notified, treatment obtained, individual wound sheet completed, care planned and added to the weekly NAR (Nutrition at Risk)review-to consist of nutritional intake weights, skin, treatments, and if wound has improved or declined by the wound nurse/designee.Non-compliance with these practices will result in further education including disciplinary action.Wound nurse/designee is responsible to ensure compliance. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? All residents currently with alterations with skin integrity were reviewed to ensure nutritional intake is monitored. Licensed nurses were inserviced on assessing residents skin upon admission and weekly, nutritional intakes and fevers by the wound nurse/designee on 11/27/2012 post test included on or before C.n.a's were re-educated on checking and changeing**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155697	A. BUILDING 00 B. WING	11/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK REHABILITATION AND SKILLED NURSING CENTER	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	section of the orders indicated, "Problem: Stage 1 & 2" and "Intervention: 1. Follow order above. 2. Call MD PRN [as needed] for follow up." Progress Notes, dated 10/31/12 at 5:54 p.m., created by the Dietary Manager, indicated, "14 day review for 10/26/12...Current wt. [weight] is 148# [pounds], down 1# since admission....Resident has two new Stg [stage] II areas on coccyx. Will rec [receive] a MVI [multivitamin] with minerals to aid in healing and low albumin, Hgb and Hct [hemoglobin and hematocrit]. Will cont [continue] to obtain weekly wts. [weights] and cont [continue] with plan of care." The Care Plan, dated 10/31/12, indicated, "Problem: Resident at risk for unintentional weight loss related to leaves 25% of some meals....Resident has two Stg II open areas on coccyx." Goal, with target date of 1/22/13 indicated, "Resident will maintain weight of 148# with no sig. [significant] change. Resident will consume 75%+ of therapeutic diet thru next review. Open areas will be healed." Interventions included, but were not limited to, "...Monitor Food/Fluid intake at meals. Monitor weight. Notify MD/family of significant weight changes...."		**residents, and turning/repositioning residents every 2 hours by the wound nurse/designee on or before 11/27/2012-post test included.Any wounds identified on admission or weekly skin assessment will be measured, MD notified, treatment obtained, individual wound sheet completed, care planned and added to the weekly NAR (Nutrition at Risk)review-to consist of nutritional intake weights, skin, treatments, and if wound has improved or declined by the wound nurse/designee.Non-compliance with these practices will result in further education including disciplinary action.Wound nurse/designee is responsible to ensure compliance. How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?The CQI audit for skin management will be utilized weekly x4, monthly x6 and quarterly thereafter.**findings from the CQI process will be reviewed monthly and an action plan will be implemented as needed for any deficient prctices below the 95% threshold.Wound nurse and DNS/designee is responsible to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155697	A. BUILDING _____ B. WING 00	11/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK REHABILITATION AND SKILLED NURSING CENTER	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

The Skin Integrity Event - ASC [American Senior Communities] Pressure Wound Skin Evaluation Report, dated 11/1/12, indicated the resident's wound to the right buttock was not present on admission, was a Stage 2 with the most severe tissue type of "Necrotic/eschar (Black, brown or tan tissue adheres to wound bed)," measured 2.0 cm X 1.5 cm X 0.1 cm, with wound color of 70% necrosis/30% beefy red, no drainage, no odor." Notes indicated, "...Resident has a Stage 1 to left buttocks and a Stage 2 to the right buttocks. Area has a dark center but no drainage or odor. It has 1 centimeter of purple surrounding wound bed...." An instructional notation on the report indicated, "Stages of pressure wounds/definitions...Unstageable - Necrotic tissue is present (eschar/black) - staging is not possible until the eschar or slough is removed."

During interview on 11/14/12 at 4:05 p.m., the Assistant Director of Nursing indicated the resident's right buttock wound was classified as a Stage 2, instead of an unstageable wound with eschar, since a portion of the wound bed was visible and beefy red.

The Care Plan, dated 11/2/12, indicated, "Resident has impaired skin integrity:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155697	A. BUILDING _____ B. WING 00	11/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK REHABILITATION AND SKILLED NURSING CENTER	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Stage 2 right buttocks." The Goal, with target date of 2/2/13, indicated, "Wound will be free from signs of complications daily through next review." Interventions included, but were not limited to, "...Encourage resident to eat at least 75% of meals...Observe for signs of infections: ...fever...." The Vitals Results for the resident's stay at the facility indicated no documentation related to food intake from 10/31 to 11/7/12 on the following dates for meals as indicated: 10/31/12: breakfast and supper undocumented; 11/1/12: breakfast and lunch undocumented; 11/2/12: dinner undocumented; 11/3/12: dinner undocumented; 11/5/12: dinner undocumented; 11/6/12: dinner undocumented; and 11/7/12: breakfast undocumented. Documentation indicated the resident consumed none of the following meals: lunch on 10/31/12 and lunch on 11/7/12. The resident's meal consumption percentages were documented as less than 75% for the following meals: dinner on 11/1/12; breakfast and lunch on 11/2/12; dinner on 11/4/12; breakfast and lunch on 11/5/12; and breakfast and lunch on 11/6/12. During interview on 11/14/12 at 4:05 p.m., the facility's Nurse Consultant and Assistant Director of Nursing (ADON)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155697	A. BUILDING 00 B. WING	11/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK REHABILITATION AND SKILLED NURSING CENTER	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated the Vitals Results record information was entered into the electronic record system by the CNAs and should be completed for every meal, so that the resident's intake on any date could be tracked. The Vitals Results for weight was provided by the facility's Nurse Consultant on 11/14/12 at 4:20 p.m. The record indicated the resident's weight on admission on 10/14/12 was 152 pounds, a routine weight on 10/16/12 was 152 pounds, and a routine weight on 11/3/12 was 145 pounds. The Vitals Results for 10/31/12 through 11/7/12, indicated the resident was checked for fever on night shift on 10/31, 11/2/12, and 11/3/12. Progress Notes and Vitals Results indicated no other vital signs were recorded for the resident from 10/31 through 11/7/12, when a Progress Note for 2:00 p.m., indicated, "Called to room by daughter. res noted to have very milky colored urine noted on penis and in brief res has a decrease in LOC [level of consciousness] but is still able to answer questions res denies pain states he doesn't really feel bad spoke to family r/t [related to] they were wanting res sent out informed them that we could do stat [immediate] labs and iv [intravenous] fluids iv abt [antibiotics] or just abt if			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155697	A. BUILDING 00 B. WING	11/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK REHABILITATION AND SKILLED NURSING CENTER	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	needed they were fine with that having hall nurse obtain v/s call out to md. [sic]" Vitals Results at 2:30 p.m., indicated temperature: 97.2 degrees Fahrenheit; pulse: 68 per minute; respirations: 18 per minute; blood pressure: 60/40. A Progress Note for 11/7/12 at 2:13 p.m., indicated the family insisted the resident be transferred to the hospital. The hospital History and Physical, dated 11/8/12, indicated, "History of Present Illness: ...He had been discharged to Clark Rehab Nursing Home. Relatives state that he has been having poor oral intake, not taking his diet. He is not drinking and his sugar has been elevated at 700 with increased immobility and increasing decubitus ulcer in the sacral area. Daughter tried to check on his decubitus ulcer yesterday and she has found that he has a lot of discharge coming from his penis...greenish material....Review of Systems: ...Genitalia: Scrotum mildly red, no ulcers. He has on the skin decubitus ulcer, stage 4...." The Plan indicated the resident would receive bolus intravenous fluids, admission to the intensive care unit, and "will consult [name of surgeon] to assist his decubitus ulcer...."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155697	A. BUILDING 00 B. WING	11/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK REHABILITATION AND SKILLED NURSING CENTER	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-40(a)(1) 3.1-40(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155697	A. BUILDING 00 B. WING	11/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK REHABILITATION AND SKILLED NURSING CENTER	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure documentation in the clinical record was complete and accurate for 3 of 3 residents whose records were reviewed related to documentation in a sample of 3. (Residents A, B, and C) Findings include: 1. The clinical record for Resident A was reviewed on 11/13/12 at 3:20 p.m. The record indicated the resident was admitted from the hospital on 10/14/12 and discharged to the hospital on 11/7/12. A. The hospital History and Physical, dated 11/8/12, indicated in "History of Present Illness: ...He has been discharged to Clark Rehab Nursing Home. Relatives	F0514	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?Resident A no longer resides in the facility**Resident B has weekly skin assessments documented in the clinical recordResident C was discharged to home **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?All residents have the potential to be affected by the alleged deficient practices. Licensed nurses were inserviced on assessing residents skin upon admission and weekly by the wound nurse/designee post test included on or before 11/27/2012.Licensed nurse will**	11/28/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155697	A. BUILDING _____ B. WING 00	11/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK REHABILITATION AND SKILLED NURSING CENTER	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	state that he has been having poor oral intake, not taking his diet. He is not drinking...." The Vitals Results for the resident's stay at the facility indicated no documentation related to food intake from 10/31 to 11/7/12 on the following dates for meals as indicated: 10/31/12: breakfast and supper undocumented; 11/1/12: breakfast and lunch undocumented; 11/2/12: dinner undocumented; 11/3/12: dinner undocumented; 11/5/12: dinner undocumented; 11/6/12: dinner undocumented; and 11/7/12: breakfast undocumented. During interview on 11/14/12 at 4:05 p.m., the facility's Nurse Consultant and Assistant Director of Nursing (ADON) indicated the Vitals Results record should be completed for every meal, so that the resident's intake on any date could be tracked. B. The Vitals Results for weight indicated the resident's weight on admission on 10/14/12 was 152 pounds, a routine weight on 10/16/12 was 152 pounds, and a routine weight on 11/3/12 was 145 pounds. A Progress Note created by the Dietary Manager on 10/31/12 at 5:54 p.m.,		**also be re-educated on compliance report for meal consumptions and completing the transfer/discharge form by the SDC/designee on or before (11/27/2012) post test included.Any wounds identified on admission or weekly skin assessment will be measured, MD notified, treatment obtained, individual wound sheet completed, care planned and added to the weekly NAR (Nutrition at Risk)review by the charge nurse/unit manager. Any residents presently reviewed in the NAR meeting have been audited to ensure weights and meal consumptions are documented accurately by the DNS/designee Licensed nurses will run the compliance report at the end of their shift to ensure meal documentation is complete-any ommissions identified will be relayed to the c.n.a. to complete prior to the end of their shift.Any resident with a transfer/discharge will be reviewed daily by the IDT/Unit Manager to ensure form completed and includes resident name, date, address that resident was transfered or discharged to, City, State and zip code.Non-compliance with these practices will result in further education including disciplinary action.Wound**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155697	A. BUILDING 00 B. WING	11/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK REHABILITATION AND SKILLED NURSING CENTER	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated, "...Current wt. [weight] is 148# [pounds], down 1# since admission...." During interview on 11/14/12 at 4:20 p.m., the facility's Nurse Consultant indicated she did not know where the weight of 148 pounds came from. She indicated she wondered if the Dietary Manager misread the weight of 145 pounds, but then realized that weight was measured after the Dietary Manager's Progress Note. 2. The clinical record for Resident B was reviewed on 11/13/12 at 11:30 a.m. The resident's diagnoses included, but were not limited to, a chronic diabetic ulcer to the right foot/ankle. Skin Integrity Event reports for the wound were reviewed for 8/1/12 through the resident's discharge on 9/23/12. Skin Integrity Events were completed weekly except for 9/13/12 through 9/23/12. During interview on 11/14/12 at 12:45 p.m., the facility's Nurse Consultant indicated there was no weekly Skin Integrity Event for the 10 days prior to the resident's discharge on 9/23/12. The Nurse Consultant indicated the Assistant Director of Nursing had the measurements and information about the resident's wound on her "composite sheet"		**nurse and DNS/designee is responsible for complianceWhat measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Licensed nurses were inserviced on assessing residents skin upon admission and weekly by the wound nurse/designee post test included on or before 11/27/2012.Licensed nurse will also be re-educated on compliance report for meal consumptions and completing the transfer/discharge form by the SDC/designee on or before (11/27/2012) post test included.Any wounds identified on admission or weekly skin assessment will be measured, MD notified, treatment obtained, individual wound sheet completed, care planned and added to the weekly NAR (Nutrition at Risk)review by the charge nurse/unit manager. Any residents presently reviewed in the NAR meeting have been audited to ensure weights an meal consumptions are documented accurately by the DNS/designee The wound nurse/designee will conduct chart audits weekly to ensure skin assessments are completed.Licensed nurses**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155697	A. BUILDING 00 B. WING	11/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK REHABILITATION AND SKILLED NURSING CENTER	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	on which she tracked all wounds in the facility. On 11/14/12 at 4:30 p.m., the Assistant Director of Nursing provided a sticky-note indicating the measurements and description of the resident's wound on 9/12/12. The information was not included in the clinical record. 3. The clinical record for Resident C was reviewed on 11/13/12 at 12:00 p.m. The record indicated the resident was admitted to the facility on 9/16/12 following total knee replacement. A. The Admission/Readmission - ASC (American Senior Communities) Nursing Admission Assessment, dated 9/16/12, indicated, "Skin Conditions Non-Wound...Surgical Incision - R [right] knee from mid-thigh to right below knee." An instructional notation indicated, "If areas of skin integrity alteration (wound and non-wound) are noted on admission measure each area and complete a skin sheet for each area." A skin sheet related to the wound was not indicated in the clinical record. During interview on 11/14/12 at 12:40 p.m., the Assistant Director of Nursing indicated there was no skin sheet for the surgical wound.		**will run the compliance report at the end of their shift to ensure meal documentation is complete-any ommissions identified will be relayed to the c.n.a. to complete prior to the end of their shift.Any resident with a transfer/discharge will be reviewed daily by the IDT/Unit Manager to ensure form completed and includes resident name, date, address that resident was transfered or discharged to, City, State and zip code.Non-compliance with these practices will result in further education including disciplinary action.Wound nurse and DNS/designee is responsible for compliance How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The CQI audits for skin management, transfer/discharge, and food, fluid intake and weight records will be utilized weekly x4, monthly x6 and quarterly thereafter.Findings from the CQI process will be reviewed monthly and an action plan will be implemeted as needed for any deficient practices below the 95% threshold.Wound nurse and DNS designee is responsible to ensure compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155697	A. BUILDING 00 B. WING	11/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK REHABILITATION AND SKILLED NURSING CENTER	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	B. The Discharge/Appointment/Transfer - Clark Rehab & Skilled Nursing Center Emergency Resident Transfer Form, dated 9/29/12 at 8:28 p.m., indicated, "Res has diarrhea since 9/28/12. C/O [complaint of] dizziness and weakness. Family requests transfer to [name of local hospital]....VS [vital signs] WNL [within normal limits]." The Notice of Transfer and Discharge form related to the discharge on 9/29/12, filed in the Miscellaneous tab of the record, failed to include complete information related to the following: Resident Name, Date Issued, the Transfer or Discharge Effective Date (month, date, year), Transfer or Discharge to Address (number and street), and Transfer/Discharge to City, State, ZIP Code. These sections of the form were left blank. 3.1-50(a)(1) 3.1-50(a)(2)			